The Secretary for Health Services
COMMONWEALTH OF KENTUCKY
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PAUL E. PATTON
GOVERNOR

MARCIA R. MORGAN
SECRETARY

September 30, 2003

Nursing Facility Provider Letter # A-195

Dear Nursing Facility Provider:

Section 1902(n) of the Social Security Act, as amended by the Balanced Budget Act of 1997, permits states to limit the payments made for Medicare deductibles and coinsurance for recipients eligible for both Medicare and Medicaid. States can limit their payment to the amounts established in their State Plan for the service. The law further states that providers must consider these payment amounts as payment in full. Recipients are not liable for any additional charges billed by medical providers.

Effective with services provided on or after November 1, 2003, the Department for Medicaid Services will begin paying ancillary services that meets the criteria of 907 KAR 1:023E in accordance with a fee for service methodology. Additionally, the Department for Medicaid Services will begin to reprice Medicare Part B crossover claims. Medicare repricing means that the provider will not receive more from Kentucky Medicaid for a Medicare crossover claim than the allowed amount for a Medicaid covered service. The allowed amount for a Medicaid covered service is being defined by the Medicaid outpatient rate reported in the Medicaid 2003 Physicians, Resource Based Relative Value Scale (RBRVS) fee schedule. Oxygen will be reimbursed in accordance with the Durable Medical Equipment fee schedule. Respiratory Therapy and Respiratory Therapy supplies will no longer be paid as an ancillary, but are considered in the routine rate through the Resource Utilization Grouping classifications.

Currently, providers do not have to bill in detail for straight Medicaid ancillary claims. Effective with these changes, each unit of service provided per day will have to be individually billed in order to be paid properly, similar to the Medicare billing of claims. Provider training regarding these billing and payment changes will be provided in the Health Services Auditorium at the Cabinet for Health Services building at 275 East Main Street in Frankfort as follows:

Tuesday - October 14, 2003 – 9:00 a.m.
Tuesday - October 14, 2003 – 1:00 p.m.
Friday - October 17, 2003 – 9:00 a.m.

As a result of moving ancillary payment from cost to a fee for service system, providers will need to file a cut-off cost report for ancillary settlement up to October 31, 2003. Please do not use Schedules NF-4, NF-5, and NF-6 for services performed after this date. You may continue to file your cost report on the original due date, but ensure that ancillary services performed on November 1, 2003 or after are not included in the ancillary cost settlement. Once all providers have had the opportunity to submit a cut-off cost report, these schedules will be deleted from future report submissions.

The Medicaid outpatient rate reported in the Medicaid 2003 Physicians, Resource Based Relative Value Scale (RBRVS) fee schedule may be viewed and/or downloaded from the Kentucky Medicaid web site, *http://chs.ky.gov/dms/*. This change is similar to the change made regarding Medicare Part A in September 2002.

If you have any questions, please contact Mrs. Sherilyn Redmon, Manager, Facilities Services Branch in the Medicaid program at 502-564-5707.

Sincerely,

Marcia R. Morgan
Secretary

Enclosure

MRM/jm

Most Frequently Asked Questions Regarding
Changes to Medicare Crossover Payment Methodology

1) Why is the Department making this change?

The Department for Medicaid Services (DMS) is faced with severe budget constraints. The projected annual savings from this change is significant and will help meet budget constraints without reducing or eliminating coverage groups or services. This will also equalize the payments for all Medicaid recipients.

2) How is this different from the way you are currently paying crossovers?

Currently, DMS pays the full coinsurance and deductible for Medicare Part B. As of September 1, 2002, repricing was implemented for Medicare Part A crossover claims setting payment at the lesser of the Medicaid allowed amount minus the Medicare payment or the amount of Medicare coinsurance and deductible, up to the Medicaid allowed amount. Using this same methodology for services provided under Medicare Part B, Medicaid will now compare the payment amount by Medicare, on the claim, to the Medicaid allowed amount. If Medicare paid up to or more than the Medicaid allowed amount, no additional payment will be made. If Medicare paid less than the Medicaid allowed amount, Medicaid will reimburse the difference between the Medicaid allowed amount and the Medicare payment. For example:

a) Medicare pays more than Medicaid Allowed Amount

- Provider bills $500 to Medicare
- Medicare allows $400 on the claim; $320 for the Medicare payments and $80 for the coinsurance
- Medicaid allowed amount for this same service is $300
- Medicaid would make no payment on the claim since Medicare's payment of $320 is more than the Medicaid allowed amount

b) Medicare pays nothing on the claim because the beneficiary is in their deductible period

- Provider bills $100 to Medicare
- Medicare allows $80 on the claim; $20 was the co-insurance amount and the Medicare payment was $0
- Medicaid allowed amount for this same service is $60
- Medicaid would pay $60 or the Medicaid allowed amount

c) Medicare pays less than the Medicaid Allowed Amount

- Provider bills $500 to Medicare
- Medicare allows $400 on the claim; $320 for the Medicare payment and $80 for coinsurance
- Medicaid allowed payment for this same service is $350
- Medicaid would pay $30 (the difference between the Medicaid allowed amount and the Medicare payment: ($350 - $320 = $30)

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3) **Will I need to bill every claim for dually eligible and qualified Medicare beneficiaries (QMBs) to both Medicare and Medicaid?**

The Department estimates that a significant portion of claims billed to Medicare are reimbursed by Medicare at an amount equal to or greater than the Medicaid allowed amount. Providers may continue to bill Medicaid for those claims that will generate additional payment up to the Medicaid allowed amount. If you are uncertain, you can continue to bill all claims to Medicaid. Remember that Medicare must be billed first for services that are considered for payment by Medicare and Medicaid.

4) **Can I bill the Medicaid beneficiary for the difference between the Medicare allowed amount and the payment made by Medicare and Medicaid on the claim?**

No. Pursuant to federal regulations, Section 1902 (a)(25)(C) of the Social Security Act, if the provider accepts the patient as a Medicaid patient, coinsurance, deductibles, and other cost sharing responsibilities may not be billed to the Medicaid recipient, recipient's family, guardian or legal representative.

5) **When is this change effective?**

It is effective with services provided on or after November 1, 2003.